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ABSTRACT

Intended to aid state departments of social services, the publication focuses on social implications of severe visual impairment and the provision of needed services. Chapters are given to the following topics: the relationship between the social service worker and the client who is blind, general terms and special services related to blindness, common caseload characteristics, children and blindness, blindness in the young and middle adult years, and the elderly blind. Stressed are the importance of coordination among various services and the role of the social worker to inform and encourage clients in the use of available resources. A list of suggested references, films, and sources of information is included. (DS)

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SOCIAL SERVICES FOR PERSONS WHO ARE BLIND

A Guide for Staff in Departments of Public Social Services

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Division of Services to the Aged and Handicapped

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social and Rehabilitation Service
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INFORMATION MEMORANDUM
SRS-IM-75-12 (CSA)
July 7, 1975

TO: STATE AGENCIES ADMINISTERING DEPARTMENTS OF PUBLIC SOCIAL SERVICES

SUBJECT: "Social Services For Persons Who Are Blind--A Guide for Staff in Departments of Public Social Services"

CONTENT: This publication has been prepared to help State departments of social services enrich and expand their programs for the people they serve who are blind.

It can be directly useful to the social work practitioner or serve as a basis for training by staff development personnel. Some of the content is also relevant to the circumstances of those who have other kinds of serious impairments.

Additional copies may be obtained from SRS Publications Distribution Center, Room G-115-B, HEW Mary E. Switzer Building, 330 C Street, S.W., Washington, D. C. 20201.

INQUIRIES TO: SRS Regional Commissioners.

John [illegible]. Young
Commissioner
Community Services Administration

FOREWORD

The attitudes and reactions of individuals with serious visual impairments and the social implications of sight loss are not well understood. There are many misconceptions about the capabilities of blind persons, and information is lacking concerning adaptations that can mitigate the effects of severe visual handicaps.

The Community Services Administration has prepared this publication to help State departments of social services enrich and expand their programs for the people they serve who are blind. We appreciate the willingness of staff members of the American Foundation for the Blind to review and comment on this material.

Social workers in local offices are primary representatives of the agency in the community. Since it is they who carry out its mission through the provision of direct services, the content of this document is addressed to their practice.

Legally blind people have always comprised the smallest numerical category of welfare clients. However the increase of serious eye pathology associated with the aging process is creating a larger number of persons 65 years of age and older who might also be classified as legally blind. Consequently State departments will be serving many elderly recipients who experience additional difficulties because of visual deficits.

The following material presents, as a guide, the kinds of services State departments may make available to eligible recipients who do not have useful sight. Such services would be in addition to the variety of provisions suitable for other agency clients.

State departments will wish to prepare their staffs to skillfully carry out the special service obligations associated with the fact of blindness. This includes being able to identify and utilize a variety of programs related to the blindness system whose resources will contribute to the well-being of citizens who are blind. The ultimate goal of all the programs and activities -- whether in the public or private sector -- carried out for visually impaired persons is, of course, to enable them to reach and sustain their best level of economic and personal independence.

Miss Sarah A. Butts, the author of Social Services for Persons Who Are Blind, has long had a special interest for visually handicapped people, and this concern is reflected in this publication. Miss Butts is also the author of Casework Services in Public Assistance Medical Care, now in its sixth printing, and of Public Assistance Social Services Related to Medicaid, in its third printing. These publications are available from the Community Services Administration.

John C. Young
Commissioner
Community Services Administration

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CHAPTER I

RELATIONSHIP BETWEEN THE SOCIAL SERVICE WORKER AND THE CLIENT WHO IS BLIND

The social service worker in a department of public social services is an initiator, an enabler, and an integrator for the planning and accomplishment of the agency's service provisions. Service activities are undertaken with the agreement and participation of the clients served by the agency.

Within this framework the worker's approach to a blind recipient1/ should not be structured by the fact of blindness anymore than it is limited by calendar age for the elderly or severity of impairment for the disabled. Rather the constructive focus is this particular person who also happens to be blind, or old, or seriously incapacitated. Otherwise the disability is likely to become the mark of identity.

Separating the person from the disability can be facilitated by forming a mental image of the individual as fulfilling such customary roles in society as husband or wife, wage earner, student, etc., without any handicap. Then what the disability has taken away from a normal existence becomes clearer. This kind of characterization may also provide the worker with clues to areas of previous activity that still interest the client, or to pursuits that can be rekindled and encouraged as a base for planning with the client.

Communication between people is facilitated by observing their facial expressions, gestures, clothing, and postures. Eye-to-eye contact is a universal way to establish interchange and rapport with people. Transactions with those who cannot see you result in an imbalance in communication because reliance upon vision to reinforce speech is not possible. The blind cannot exchange nonverbal signals to the extent the sighted do with other sighted persons. Such lacks can be disconcerting to the worker but need not be serious hindrances. It is well for the worker to keep in mind that these clients have their own problems in trying to "size up" someone they cannot see.

1/ Throughout this publication, reference to the blind or visually handicapped person designates an individual who happens to have seriously y impaired sight. The social service population encompasses blind adults and children who receive cash assistance or benefits in accordance with current provisions of the Social Security Act.

Before a meaningful relationship can be established between the social service worker and the client, the client needs to discover and test out something about the worker's attitudes toward him,* some of the reasons for their association, as well as the benefits that could result from it. This process occurs whether the client's sight is severely limited or not. However when the client is blind, more effort, understanding, and use of verbal communication may be necessary on the part of the worker in order to establish a climate that is comfortable for both of them.

At first it may be difficult for a sighted social worker to gain the confidence of a blind individual. There are numerous reasons for this. The general population, for example, regards blindness as one of the most dreaded physical threats, and encountering a blind individual personifies the reality.

Since blindness is not such a common occurrence, many people, including social workers, have had little personal contact with this special population. Their relatively small number, geographical spread, and isolation keep them out of general view. Thus beliefs that used to prevail may still be accepted, such as the idea that loss of sight sharpens other senses as compensation; that blind persons substitute rich inner lives for the satisfactions of a sighted existence; that blind people must and do assume passive roles, relying upon the sighted to meet most of their needs; that the blind must be afforded a special status, etc. Hopefully the medieval belief that the blind possess magical powers or that blindness is divine punishment has disappeared.

RESPONSE OF THE WORKER TO VISUAL IMPAIRMENT

Some service workers, because of their backgrounds and temperaments, are able to establish quite readily a positive relationship with their blind clients. For others the association is characterized by feelings of unease and dismay, which are not unnatural responses. In order to be effective, however, a service worker needs to be free from such inhibiting reactions. These subjective responses often derive from a combination of past experiences and concerns that surface when she is face to face with a blind individual.

The worker who can recognize what is happening has taken a first step toward substitution of a more realistic attitude. She will gain perspective by keeping her personal circumstances separate from those of the client.

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* To avoid repetition of the often awkward phrases "he or she," "him or her," "his or her," etc., we have used the masculine pronoun to designate the client and the feminine pronoun to designate the social worker.

A personal fear of the blind may be rooted in deep anxiety about losing one's own vision. There is correlation between the worker's dread of blindness and a sense of guilt because she is sighted while others are not — a situation that could so easily have been reversed.

Not all blindness, however, is evident to the onlooker. When it is apparent, cosmetic defects can be prominent and, consequently, upsetting to an observer. "Blindisms" — i.e., the mannerisms of some adventitious and congenitally blind people — might "throw you off." Such children and adults may rock back and forth, twitch, poke at their features, reach for and touch objects on the interviewer's desk, have an unresponsive facial expression, fail to face the person addressing them, or behave in other disconcerting ways.

The prospect of providing services to blind people, especially those who are very dependent, may seem overwhelming because so many needs are present. It is not surprising that an inexperienced worker placed in such a situation could feel threatened and, therefore, unsure about offering any services.

While it is certainly true that there is no restitution for irreversible and extensive visual loss, this is not to say that many positive steps, both big and little, cannot be taken to enable blind individuals to carry as independent a role in life as their capabilities allow. Unfamiliarity with the severely visually handicapped is likely to result in underestimating or devaluating both their present and potential capacities. This can have the unfortunate consequence of neglecting to find and develop the kinds of independence that are the right of all visually disadvantaged people.

RESPONSE OF BLIND PEOPLE TO THE SIGHTED

While the sighted have a variety of beliefs about the blind, the blind also have their special attitudes toward the sighted. The service worker should be aware of how these views, which reflect individual differences, of course, can influence her role and plans in relation to a blind recipient. For example a client may wonder how the worker feels about his visual loss. As one client succinctly asked, "Do you understand me?"

A legally blind person with some residual vision may not regard himself as blind. Consequently he will avoid associations that identify him with the blindness system, its services, and specialized programs, since to do so would be evidence that he considers himself blind — an unacceptable role. Because the service worker is interested in all clients who receive Supplemental Security Income (SSI) payments, she is not likely to be identified in the client's mind as a representative of "a blind agency." This can be advantageous.

If, however, vision gradually dwindles, finally reaching the level of legal blindness, the elderly especially may not perceive enough difference between "what was" and "what is" to realize they actually can be considered blind. This is particularly so when poor sight has become one of a number of other debilitating and lasting health problems. Then blindness is likely to be relegated to the background because "it doesn't hurt." In such cases the person may not refer to his loss of sight because other bodily ailments are more distressing.

A client may harbor resentment toward all persons who can see. There are many reasons for this, including unresolved problems that hinder acceptance of the handicap. The more mature blind individual is unwilling to allow his whole identity to be submerged or overridden by the nature of his visual loss. This person will need to determine whether a sighted worker realizes that his impairment is only one dimension of his total personality.

By contrast some people who are blind feel that only other blind persons can be understanding and helpful. This may reflect personal concerns about being exploited or manipulated by the sighted — even injured from exposure to hazardous situations.

How an individual felt toward blind people before his own loss of sight may be a factor that determines how he will handle himself now. The person who has made a satisfactory adjustment to visual loss will feel free to be himself; he does not want to be categorized as just another member of a handicapped minority. Then it is easier for the worker and client to mutually establish plans and services. These services may have little relevance to the fact he is blind. Pity and overprotective actions by the worker that detract from any client's independence are readily discerned and are likely to hamper their partnership.

FACILITATING INTERVIEWS WITH PEOPLE WHO ARE BLIND

The social service worker should extend to the blind client the same consideration she would to a sighted one. However she will have to make some special efforts to establish meaningful communication.

Some of the common sense actions the worker should take at the beginning of an interview include assuming the initiative in identifying herself and speaking directly to her client in a normal tone of voice. At the same time, she should extend her hand and grasp the hand of the visually handicapped person.

Unless an additional difficulty, such as a language barrier or hearing loss, interferes with communication between client and worker, conversation carried on through a third person is not desirable. Blind persons tend to feel disparaged by 3-way exchanges. When other persons

are present the worker should mention them, regardless of whether or not they are expected to share in the discussion. This information, besides showing courtesy, may be very significant to the client in deciding what he wants these other people to know about his affairs.

The worker should allow sufficient time to explain agency rules and procedures. When there are forms to be signed, the worker needs to explain them thoroughly and in terms the client will understand. Concerning vocabulary, there are no reasonable equivalents to words that pertain to vision, such as "see" and "look," and to try to avoid them or to substitute other expressions will sound artificial. In fact people who are blind use these words themselves.

The worker should let the client know when the interview is over.

IN SUMMARY

Blind people have a variety of attitudes pertaining to those with normal vision. Shifts back and forth in their feelings toward the sighted may be occasioned by new stresses, changes in health, personal maturation, etc. Consequently it is important for the service worker to be cognizant that not only her own perception of the visually handicapped client but also the latter's attitude toward her and others without a similar handicap will exercise a subtle influence on their association. Blindness itself has a unique significance for each person with this impairment. Understanding its meaning, person by person, will enable the social worker to develop the realistic relationships that are basic for a productive outcome.

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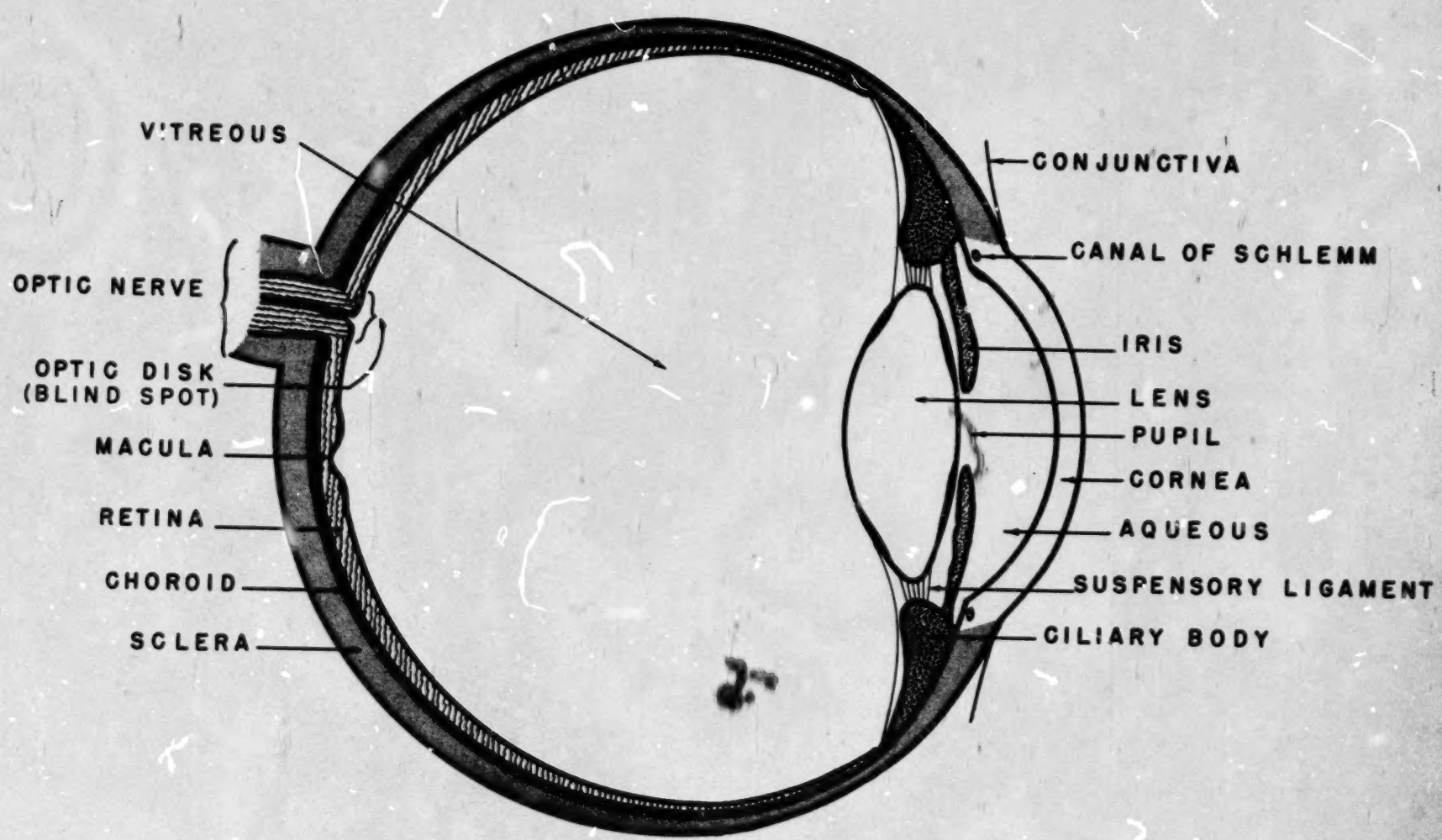

CHAPTER II

SOME GENERAL TERMS AND SPECIAL SERVICES RELATED TO BLINDNESS

GENERAL TERMS

Sight.—Sight can be defined as the human sense which gives details and relationships of form, size, and position of objects and symbols. Thus loss of sight causes a detachment from the physical and, to a lesser degree, from the social world.

Central Visual Acuity.—This is the ability of the eye to perceive the shape of objects in the direct line of vision.

Normal Vision.—This is stated in terms of metric measurement. Medical science has adopted use of Sneller Chart measurements to determine normal vision, referred to as 20/20. The latter measurement means a person can read a specified line on a Snellen Chart at a distance of 20 feet without glasses. With the help of eye glasses, many peoples' sight can be improved to 20/20.

Legal Blindness.—It is necessary for administrative purposes to have a measurable point for determining when a person's vision is so impaired as to seriously interfere with his education and livelihood; in other words, the presence of impairment that results in "economic blindness."

An individual is ordinarily considered blind if visual acuity does not exceed 20/200 in the better eye with correcting lenses, or if the visual field is so restricted the person can see only a very small area at one time (20 degrees or less). In lay terms a person is considered blind if, at a distance of 20 feet or less, he can see no more than what a person with normal sight can identify at a distance of 200 feet.

This legal definition of blindness is used as a basic eligibility condition for SSI and for income tax exemption. It reflects the definition of economic blindness, recommended in 1934 by the American Medical Association, to be used in determining public assistance for

Title X (Aid to the Blind) of the Social Security Act that was initiated in 1935. The definition has never meant total sightlessness. Some residual vision remains for about 80 percent of the legally blind.

Congenital Blindness.—This refers to blindness which exists at birth for whatever reason.

Adventitious Blindness.—This is the opposite of congenital blindness since loss of sight is due to such causes as accidents, eye injuries, or disease occurring during a person's life.

Peripheral Vision.—With normal vision a person looking straight ahead without moving his eyes can also perceive the presence, motion, or color of objects on each side and above and below the line of sight. If this peripheral vision is cut to the extent that the angle of sight only takes in 20 degrees or less in the better eye, the person is considered legally blind.

Ophthalmologist.—An ophthalmologist is a physician who specializes in the diagnosis and treatment of all defects and diseases of the eye by prescribing drugs, glasses, and other types of treatment including surgery. The initials M.D. are used after the ophthalmologist's surname. Oculist is another designation for an ophthalmologist.

Optometrist.—An optometrist is a licensed practitioner who specializes in the measurement of refractive errors and eye muscle disturbances. The optometrist treats these conditions by using corrective glasses, prisms, and exercises. The initials O.D. are used after the optometrist's surname.

Optitian.—An optician is trained to grind, fit, and supply eyeglasses prescribed by an ophthalmologist or optometrist.

CAUSES OF BLINDNESS

Glaucoma.—A leading cause of blindness after the age of 35, glaucoma is due to increased pressure on the optic nerve, reduced blood supply within the eye, and consequent damage to the nerve cells. The area of peripheral vision gradually decreases, and without treatment the disease may result in total blindness. Except in an acute phase,

progression is usually painless; however, lost sight cannot be restored. Prescribed eye drops on a daily basis will frequently arrest the course of the disease. Because glaucoma is viewed as basically a genetic disease the onset of which cannot be prevented, the adult relatives of glaucoma patients should have regular ophthalmological examinations to assure early diagnosis and treatment if the condition is present.

Cataract.--Like glaucoma this sight problem cannot be prevented. Senile cataracts, the most common form, are associated with the later years of life, and as the life span is extended affect more of the elderly population. Cataracts are caused by an opacity or loss of transparency in the normal lens that obstructs the passage of light rays necessary for sight. Hazy vision is a common sign of the presence of cataracts. Fortunately surgery which is recommended for the great majority is 90 to 95 percent successful, even among people of advanced age. In fact it is one of the most successful surgical operations performed today. Removal of the lens requires the wearing of special cataract glasses or contact lenses. The advantage of the latter is that it provides a greater field of vision than can be obtained with the other type of glasses. Congenital cataracts are caused by hereditary influences, while the traumatic types are those associated with injury.

Macular Degeneration.--This, too, is increasing the number of persons with seriously limited sight because it is related to aging, and the reduced central vision that results cannot be restored. It does not generally end in total blindness, so low vision aids can be useful. The macula is located in the retina and controls the central field of vision, the area of sharpest and clearest vision.

Diabetic Retinopathy.--This is a major cause of blindness and occurs in both young and old people in conjunction with diabetes. Damage to the blood vessels in the eyes results in destruction of the retina. It should be pointed out that the disease does not happen in all cases of diabetes. The number of individuals with this condition is increasing, partly because more people with diabetes are being identified, treated in the early stages, and thus live longer. Because the fingertips of persons with diabetes and other debilitating diseases may have less sensitivity, the use of braille is not always a feasible plan.

Retinitis Pigmentosa.--This is a hereditary disease for which there is as yet no effective treatment. Therefore it is important that other family members be tested and that they understand the risk of transmitting such a birth defect. In this disease the retina progressively degenerates resulting in more and more diminution of

peripheral sight. Especially at night, remaining vision is lessened which is the reason the condition, in nonprofessional language, has been referred to as "night blindness." Since reading vision usually remains, low vision aids are of benefit.

Retrolental Fibroplasia.--This condition is the result of an excess of oxygen given to premature babies of low birth weight. During the 1940's and early 1950's it was a frequent eye disorder among such babies placed in hospital incubators. When the high amount of oxygen was identified as the cause of the condition, it came to a dramatic end except for some isolated cases. However the survivors from that type of care are now adults and comprise a small percentage of the blind population.

Rubella.--In lay terms rubella is referred to as "German Measles." It is caused by an environmental, not a genetic, factor. When a child spreads rubella to a pregnant woman, her unborn baby may be severely damaged -- not only blind but perhaps deaf, with other serious handicaps as well. There are now licensed vaccines that can prevent such consequences. (During 1964-65, this country had a rubella epidemic.)

SPECIAL DEVICES

Large Type Books.--Many people with some residual vision can read large type -- 14 to 18 points (about 3/16 to 1/4 of an inch) or larger. Consequently these books are sizeable -- 8-1/2 by 11 inches. Many local libraries lend them. If not the public library or a bookshop can supply names of commercial publishers. The New York Times prints a weekly large type edition. The American Bible Society and the Readers Digest also provide this enlarged type. For years public schools have used large print textbooks to teach some partially seeing children.

Braille.--This is a system of printing and writing for the blind in which raised dots designate letters, numerals, and punctuation marks that can be distinguished by the fingers. Words are formed by the number and arrangement of these dots. Braille is written with the aid of a metal slate and stylus or a specially constructed braille typewriter.

Nonprofit organizations such as the American Printing House for the Blind (Louisville, Kentucky) and the Howe Press of the Perkins School for the Blind (Watertown, Massachusetts) produce large numbers of braille books and periodicals. Single copies for special subjects with a limited circulation may be made by volunteer transcribers.

Talking Book Machines.--These are phonographs which play recordings of someone reading books, magazines, etc. Usually recorded at 8-1/3 rpm.,

each record takes about 3 hours of listening time. Eight to ten hours is the usual period to hear a book. The books and magazines are chosen for all age levels and include the types of reading selections available to sighted persons using an average public library. About 40 percent of the books are now on magnetic tape cassettes which are easier to handle than records. The cassette players are also easier to operate than phonographs. Within the next few years the phonographs will be replaced by cassette machines.

Talking book machines as well as braille volumes (including music scores) and pamphlets are provided without charge through regional circulating libraries for the blind by the Division for the Blind and Physically Handicapped, The Library of Congress. Library materials are shipped postage free both ways to borrowers. Since 1966 this program has been expanded to cover people unable to read conventional print materials because of other physical limitations. Some regional libraries arrange for staff to visit the homebound and those in institutions to offer assistance in selecting books; they may also deliver books and equipment. Such contacts make the service more personal.

Aids and Appliances.--Many aids and appliances have been adapted or designed to assist the blind person in handling many everyday transactions at home and at work and for recreation. They include kitchen equipment with raised markings and safety features; a variety of games and puzzles in braille; watches, clocks, and timers with raised numbers; sewing aids and tools; such medical aids as an insulin syringe for blind diabetics. A major supply source is the Aids and Appliances Division of the American Foundation for the Blind (AFB) which operates a mail order service at cost. The AFB free catalog of some 300 items is updated annually and is issued in both braille and ink print editions.

Optical Aids.--These are visual devices, often referred to as low vision aids, that have been developed to enable people to maximize even a small amount of residual sight. Such aids, when ordinary spectacles are no longer useful, include magnifying glasses of various types for close-up vision; telescopic lens for distance viewing; and closed circuit television systems that enlarge and project print onto a television screen.

A physician should be consulted in order to assure selection of the proper optical aid. Many devices must be prescribed and special training given to ensure correct use. Low vision aids may be more suitable after the active phase of eye treatment is finished. A number of eye hospitals and eye clinics have low vision aid facilities that recommend and fit optical aids. Proper lighting is especially important for those with low visual ability.

SPECIAL TEACHING SERVICES

Instruction in Orientation and Activities of Daily Living.--These are

basic services and refer to reeducation of the individual with serious visual handicap by enabling him to function through the use of his other senses and with appropriate aids. Orientation is concerned with the adaptation of the blind person to his environment in order to provide a basis for learning the techniques of personal management. Activities of daily living include such functions as eating, bathing, pouring liquids, identifying coins and handling paper money, shaving, cooking, dialing a telephone, telling time, and caring for personal belongings. There are well-established techniques for teaching all of these and other essentials.

Though job titles differ among agencies, it is a rehabilitation teacher -- formerly called a home teacher -- who is professionally trained for such teaching. The rehabilitation teacher is employed by an agency that includes as a special function the organizing, planning, and directing of teaching services to blind and visually handicapped persons. The instruction may be given in a public or private rehabilitation center serving such persons, or it may be given in the client's home.

Mobility.--This is another aspect of personal adjustment training and is closely related to orientation. It teaches the individual how to become aware of his surroundings and to move with assurance. Instruction in travel performance is taught on a one-to-one basis for the purpose of enabling blind and visually handicapped persons to travel safely, effectively, and efficiently in indoor and outdoor environments through maximum use of their remaining senses and with sensory aids and devices. It includes learning how to utilize travel aids such as sighted guides, long or prescription types of canes, and, for some, a dog guide.

Mobility instructors are sighted. They are professionally trained at the baccalaureate and master's level for this very specialized field. They are employed in public and residential schools, rehabilitation centers, and agencies for the blind. Mobility instructors may also teach orientation.

The goal of all these kinds of special instruction is to enable each visually handicapped person to be independent in as many activities, large and small, as his abilities allow.

Genetic Counseling.--Genetics is the branch of science concerned with heredity. Counseling in this field is a specialization that provides and explains information about human genetics for the purpose of preventing the occurrence of birth defects. The latter may be inherited (e.g., retinitis pigmentosa) or due to other unfavorable prenatal factors such as faulty body chemistry that result in physical and mental abnormalities. An ophthalmologist is a logical source to consult for information about the extent of genetic risk in having a first child or later children when an inherited eye disease is present in the family of either parent.

CHAPTER III

COMMON CASELOAD CHARACTERISTICS

The number of blind persons in this country can only be estimated since no method exists for obtaining a reliable and current count. However a recent study1/ by the Metropolitan Life Insurance Company of half a million blind people in the United States showed that:

- Three out of every four blind persons are over 45 years of age.
- Three conditions account for approximately half of all blindness: retinal disease (in which complications from diabetes loom large), cataracts, and glaucoma.
- The extent to which the rate of blindness is linked to age is underlined by the following figures: at ages 45-64 the rate of blindness is 200 or less per 100,000 population; at 65-74 years it is 440; between 75-84, 900; and at 85 years and over it reaches 2,600, or more than 13 times the rate for the 45-64 age group.
- The highest regional rates are in the East South Central, South Atlantic, and West South Central regions of the country which are also characterized by below average income, poor health services, and a high proportion of nonwhites.

As someone has already said, "Statistics bleed" and service workers can readily translate the preceding figures to fit the pattern of clients in their caseloads. In contrast to the earlier Social Security Titles I, X, and XIV, both Title XVI (Supplemental Security Income) (SSI) and Title VI (social services for persons eligible for SSI) of the Social Security Act cover the aged, blind, and disabled.2/ Title XX

1/ Profile of Blind Persons. Statistical Bulletin 54:9-11 (July 1973). New York: Metropolitan Life (1 Madison Avenue, New York 10010).

2/ The SSI program and Title VI (and after October 1, 1975, Title XX) do not apply to Puerto Rico, Guam, and the Virgin Islands. Title X (Aid to the Blind), part of the original Social Security Act, remains in effect as well as Title I (Old Age Assistance), Title XIV (Aid to the Permanently and Totally Disabled), and Title XVI (combining Titles I, X, and XIV).

(Grants to States for Services) which replaces Title VI and which becomes effective October 1, 1975, will continue the same combined coverage.

Scrutiny of the caseload of a service worker shows that the economic requirements and social and physical deficiences of these three populations are not really separable in many respects. However, current laws do categorize within each title on a calendar basis by identifying "65 years and over" as a major criterion for receiving money and/or services to benefit "the aged." The legislation also differentiates between the blind and disabled on the basis of medical findings.

SIMILARITY OF SOCIAL SERVICE NEEDS

The provision of services should not result in a rigid pattern for providing social services; e.g., the blind in contrast to the aged. The great majority of persons 65 or older who are also blind will, by reason of years (if other eligibility factors are met), be classified by SSI as aged. Such an administrative procedure intermingles elderly and blind people. As the Metropolitan Life Insurance study figures show, the rate of blindness is more than double for those 65-74 compared to people between 45 and 64. Those 75 and over are even more likely to have the severe burden of advanced age and severe visual loss. The significance for social workers of this classification pattern with respect to their own work is to avoid categorization of clients as "old" or "blind" when in fact they are both. Service needs frequently arise from the presence of each condition but are not necessarily of the same kind or present the same degree of urgency.

Blind persons receiving or eligible for SSI funds and social services comprise a "cradle to the grave" population — infants to oldsters. Consequently the service worker is challenged to carry a meaningful role with such a varied group. At the same time, this diversification provides opportunity for richer satisfactions. The common denominator of legal blindness is the one attribute they all share. Beyond that the threshold to understanding and giving social services is recognition that loss of sight is only one dimension of the total personality of a particular client who is now blind. The significance of this loss to recipients and their families encompasses wide variations and may not affect them in the same way from day to day.

Much has been written about the effect upon the previously sighted of blindness that results from accidents, injuries, illness, etc. Especially where the onset is sudden or fairly rapid in contrast to the gradualness of certain degenerative eye diseases, the traumatic experience is very much heightened. This is true not only for the person affected and his relatives but also for other persons who are important in his life. Time is a significant factor in overcoming the shock.

Some particular circumstances are connected with visually impaired SSI recipients. The occurrence of their blindness has, of course, preceded an application. Then, determination of all the factors of eligibility to process a claim may require some time. Establishment of SSI status based on legal blindness is evidence the recipient (except the very young) acknowledges his blindness. Acceptance of the condition, however, does not necessarily follow. As an example, he may feel the eye condition is not permanent, although medical findings state otherwise.

A requirement of SSI (except for the young, old, and those with additional serious handicaps) is referral for vocational training or retraining through the State rehabilitation agency. This referral and training sequence reinforces the client's perception of himself as legally blind.

As a result of the foregoing, a considerable interval may transpire between the date of application and the service worker's first contact with the SSI applicant. Meanwhile a recently blinded eligible recipient has made an initial accommodation to visual loss. The nature and extent of help, if any, that he received during this crucial period will have an effect upon his new pattern of adjustment. Such help may or may not have been constructive. This is an important point for the worker to keep in mind.

THERE IS A LARGE BODY OF KNOWLEDGE CONCERNED WITH THE IMPACT OF SEVERE VISUAL DEPRIVATION AND WITH THE PROVISION OF A RANGE OF SERVICES THAT FOCUS UPON THE PERSONAL DEVELOPMENT AND SELF-SUFFICIENCY OF PERSONS WHO ARE BLIND.

CHRONOLOGICAL AGE IS A LOGICAL PATTERN TO FOLLOW IN DISCUSSING THE SOCIAL SERVICES THAT ARE AVAILABLE TO ELIGIBLE INDIVIDUALS IN ACCORDANCE WITH THE PROVISIONS OF AN APPROVED STATE PLAN.

CHAPTER IV

CHILDREN AND BLINDNESS

Children who are blind can be divided into two groups: (1) those with the single handicap of blindness and (2) others who are multihandicapped; i.e., they have a severe visual handicap plus one or more additional impairments such as mental retardation, cerebral palsy, hearing loss, or an orthopedic problem. A combination of such defects is not unusual for "rubella babies."

The perplexing questions faced by parents of all blind children are serious and lasting. When the blind child has sighted siblings, additional adjustments are necessary on the part of each family member. Fortunately an increasing number of counselors and teachers are now professionally prepared to provide expert guidance to these children and their families. But the need still exceeds the supply.

Public schools are increasingly assuming educational responsibility for blind children, including those with additional handicaps. In recent years more skillful evaluation of the needs of blind and multihandicapped children has encouraged discriminating use of residential settings, foster care homes, and other alternative arrangements. As these children grow, their developmental needs and behavior patterns change too. Consequently a series of placements may be necessary to consolidate earlier gains and to assure a basis for continued progress.

Since a child who is entitled to SSI payment will not be suitable for vocational rehabilitation planning before his mid-teen years, the social worker has a particular responsibility to offer services to his family and to follow his individual development. Full utilization of medical resources is a major aspect of this task.

Beginning January 1, 1974, blind and disabled children for the first time became eligible as individuals for Federal cash assistance. (A large number had been receiving Aid to Families with Dependent Children, Title IV-A.) On that date, many were transferred by State departments of welfare to SSI. In general the great majority of these young recipients continued to be entitled to Medicaid (Title XIX). States, however, have the authority to limit Medicaid coverage based on their January 1972 standard of need, so inclusion of the children may not always be automatic, particularly for the medically needy. Thus it is necessary that the service worker understand the specific eligibility provisions of her own State Medicaid plan.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

Eligible blind children are entitled to all the medical and remedial care and services included in a State plan for medical assistance. Actually these children comprise a high risk population due to the severity of their eye problem and its effect on sound growth and development. In addition the SSI population under 21 years of age belong to a low income group eligible for special health care -- also a required part of Medicaid. This is made possible through the program of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Through EPSDT the young from poor and marginal income families are assured for the first time the scope of preventive health care that has been lacking for far too long.

EPSDT is a broad, ongoing program whose purpose is to ensure that children from needy families receive comprehensive health care through periodic surveys to identify and diagnose their health needs and then to receive any necessary preventive and curative services. Mental as well as physical health is taken into account. The focus here shifts from crisis intervention to developmental and anticipatory measures.

A medical eye examination to determine legal blindness for SSI is simply that. The person's visual treatment requirements do not have to be noted. Even the most complete diagnostic eye examination cannot be a substitute for a general health examination. Blind children need the latter as much — perhaps even more — than their sighted peers. A significant social service is to assure that every blind child receiving SSI payments has full advantage of the EPSDT opportunity.

Screening procedures are primarily designed to detect eye and hearing defects, heart and dental problems, anemia, sickle cell diseases, lead absorption, and to ascertain immunization status. Assessment and evaluation of other related conditions such as nutritional status may be included. Recommended glasses, hearing aids, dental treatment, etc., can be paid for by Medicaid. EPSDT is not the source of treatment for acute illness or injury because such care is included in other Medicaid provisions pertaining not only to the young but to other age groups.

CONTINUITY OF CARE ESSENTIAL

Service workers will need to assist many families of young blind clients in finding and using Medicaid resources. Staff from other specialized treatment programs, public and private, will often be participants in serving these families. To assure continuity and completion of care may require interpretation over a long period of time of a medical regimen as well as liaison in the family's behalf with physicians, nurses, and clinic personnel. This is sometimes called "tracking" or "follow-along."

There is real danger that in the area of health, the blind person's visual disability and related eye care (if any) obscures the necessity of regular medical attention to the rest of his body. The worker is in a strategic position to counteract such tendencies. The correction or reduction of treatable conditions, even minor ones, can enhance the handicapped person's self-image. At the same time, continuity of care serves as evidence that others are concerned with his situation.

Assistance in meeting the health requirements of blind children is not the only area in which agency support may be needed. The service worker should have some perception of the everyday realities of living with severe visual loss, both for the child and his family in order to focus on additional specialized help they may need, such as in individualized educational placement.

NEEDS OF INFANTS

Since a major amount of learning depends on vision, the congenitally blind child is severely disadvantaged even as an infant. Due to the obviousness of the condition, the diagnosis of blindness is likely to be made in the first year of life. Severe visual loss, but not total, would be noted before the child is of school age.

The deaf-blind baby is even more isolated. From birth to 3 years is the period when a child must start to develop his own testing of the environment as a basis for later patterns of independence, social interaction, and readiness for learning. The blind infant has to be guided through this process in spite of his visual handicap if he is to receive a fair chance in the sighted world. Stimulation to use all his senses — particularly hearing, touch, and smell — as well as any residual vision is essential. The need for bodily exercise including crawling, walking, and climbing must be safely mastered to develop stamina and physical vitality. The child must explore the boundaries of his world; otherwise the consequence may be passive and overdependent behavior.

Realization that their child is blind is devastating to parents. Supersensitivity, self-accusation, and feelings of guilt are experienced by most when faced with the irreversibility of their child's eye condition. A handicap of this nature creates special and lasting emotional demands on parents and other members of the family.

Parents do not know what to expect of a blind child or how to encourage his optimal development, and this knowledge is not part of the service worker's expertise either. Rather her role is to recognize with the parents and in behalf of the child that the demands of everyday living for both are more complicated due to the loss of sight but are not

necessarily overwhelming since special kinds of aid are available. She should make every effort to locate or to assist the parents in finding appropriate resources, including qualified counseling. The worker should encourage the parents to accept and utilize these resources since parental cooperation will be the essential foundation for success. Assistance should not be postponed either, because delay may diminish the child's chances for improvement.

The nature and source of specialized help will vary, of course, with the child's age, degree of residual vision, and presence or absence of other defects. As the blind child grows from infancy through preschool to the school years, the kind and extent of guidance he receives has to be suited to his developmental timetable. For some families continuity of services must be maintained to prevent regression and to further progress. Followup cannot be left to chance, and areas of responsibility should be clearly defined among the agency personnel who provide any service. When the teenager reaches the age of vocational rehabilitation counseling, there may be an additional collaborative relationship. Since the majority of legally blind young have the same mental and physical capabilities as the sighted, except visually, they should be properly prepared for a productive occupation.

MULTIHANDICAPPED CHILDREN

Success in the upbringing of blind and otherwise handicapped children is measured differently than for the able-bodied. For example, children who are deaf-blind, brain-damaged, or have different severe defects may not have the stamina or capacity to make use of academic programs. Instead the goal may be to teach self-care and daily living skills, where progress is only evident in small steps. Sometimes multihandicapped children are considered mentally slow or emotionally disturbed due to the social consequences of their physical problems. Testing methods are now evolving that evaluate with greater accuracy the intellectual and attainment levels of this group of children. Also more research efforts in the field of severe impairments show hopeful results of greater potential for the educability of these children than was previously believed. The development of even very limited capabilities to the person's upper limit can bring satisfactions for those who are concerned about the child's welfare. It is important for the worker to remember that any improvement in the quality of life for these disadvantaged children is worthwhile.

In a recent research study1/ made by the Rand Corporation and sponsored by the U.S. Department of Health, Education, and Welfare, a

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1/ Kakalik, Brewer, Dougharty, Fleischauer, Genensky, and Wallen: Improving Services to Handicapped Children: With Emphasis on Hearing and Vision Impairments. Santa Monica, Calif.: Rand (1700 Main Street, 90406) 1974. 329 pp. (p. 277)

small sample of families with multihandicapped children were asked to rate their children's most important service needs. First on the list was education; after that, medical services and sensory aids. This group of families -- selected from an Eastern, Western, and Mountain State -- had trouble learning where services were available. They also found that the quality of service was less than needed and that the mix of services the children required were not all within a reasonable distance from their homes. Although public social service staffs are familiar with all of these problems, there is an extra urgency for action for families with multihandicapped children because opportunities for correction and learning are the most favorable during childhood and youth.

IMPORTANCE OF SUSTAINING LINKAGE WITH OTHER CARE PROVIDERS

The social worker's main function may well be one of firm linkage -- that is, joining family to resource and vice versa -- with a sustaining interest to maintain the continuity of services, again between clients and providers. The process is time consuming, often tedious, and may result in few thank you's. Nevertheless the activities serve to act as an agent, perhaps the only one that binds essential services together for the benefit of their mutual clients. (Some agencies use the term "case manager" for this responsibility.)

Even the most knowledgeable people encounter difficulty in attempting to "access the system" when they seek some sort of aid. The scarce and uneven distribution of services for the handicapped has created a maze that most clients cannot negotiate alone. Separate, often restricted funding sources, coupled with the variety and maldistribution of specialists, are part of this picture.

Blind children seldom need a single type of help, so multiple resources must participate though perhaps not simultaneously. Thus the chances for splintering become greater. Comprehensive care centers or one-stop service programs could be solutions, but such settings are far from being universal in this country.

Certain well-established sources exist to whom the agency worker may turn for assistance in obtaining services for visually disadvantaged clients. If such organizations are already in touch with clients, social services may still be in order through work with relatives or utilization of any of the other regular items included in the State scope of social services. The following is a listing of some of the kinds of agencies that provide basic types of services.

PUBLIC RESOURCE PROGRAMS

State vocational rehabilitation agencies have a special commission, unit, or division to provide training and counseling to the visually

handicapped and their families as well as other specialized services. The comprehensiveness of these programs varies between States.

State and local boards of education have responsibility for the schooling needs of exceptional children including the visually handicapped. In large cities departments of special education carry out this function for the physically and mentally handicapped. Specialized teaching is provided for the homebound and for children in certain institutional settings. Some districts offer free busing or other means of travel so these children can attend classes. School health programs may be an advantage; considerable variance can be found between jurisdictions.

State and local departments of health — through their Maternal and Child Health (MCH) and Crippled Children's (CC) programs — provide care for many types of handicaps. MCH is concerned with preventive health services, child health supervision, and fostering good parent-child relationships. They conduct screening, immunization, and mental retardation clinics. CC services focus on crippled children under age 21 and on those suffering from conditions that can lead to crippling. Like MCH, the CC program has become more inclusive and accepts other handicaps in addition to crippling. The program operates treatment and diagnostic clinics — some on an itinerant plan in rural areas — and provides medical care and health supervision. Public health nurses in these and other programs are an important ally of the service worker in extending health care to all handicapped people.

State departments of mental health or hygiene, through local counterparts, can give attention to the emotional conflicts and stresses that frequently accompany visual loss.

Head Start programs are required to accept a proportion of handicapped children, so this might be an opportunity for the preschool age blind child.

Following the 1964-65 rubella epidemic, Congress approved two related programs to provide a continuum of services for deaf-blind people. These were the establishment of ten Regional Centers for Deaf-Blind Children and the National Center for Deaf-Blind Youths and Adults. Each of the Regional Centers serves deaf-blind children within their area who cannot benefit from special educational programs for either the hearing handicapped or visually handicapped. Registries of deaf-blind children are compiled; the adjustment and training needs of each child are studied by Regional Office professional teams; suitable educational programs are arranged; and parent counseling is available.

The National Center for Deaf-Blind Youths and Adults (presently located at 105 Fifth Avenue, New Hyde Park, New York 11040) is a

comprehensive residential rehabilitation service for the United States and Territories. The Regional Offices of the Center assist State and local agencies in serving deaf-blind youths and adults in their own communities.

Specific inquiries about client referrals to these Centers can be directed to the State Rehabilitation Agency, Division for the Blind, or to the State Department of Education, Division of Special Education.

PRIVATE RESOURCE PROGRAMS

Among the private organizations on the national scene is the National Easter Seal Society for Crippled Children and Adults. Their local chapters may accept visually handicapped children with other impairments.

The American Foundation for the Blind does not have a program for direct services but serves local agencies in that field in a consultative capacity. Their five offices -- located in New York City, Atlanta, Chicago, Denver, and San Francisco -- function as resource and referral centers for professionals and others seeking services for the blind and severely visually impaired of all ages. Additional specialists are located in the New York City headquarters. In addition to carrying on an active educational program for the public and for those working in the field of visual disability, the Foundation sells, at cost, special aids and appliances for use by blind people. They also publish a directory of agencies that serve the blind.

When mental retardation is associated with blindness, the resources of programs for the retarded should be explored.

Eye hospitals and clinics would be helpful, and private agencies for the blind often have specialists in the field or know where they can be found. County medical societies and Lions Clubs and other civic organizations may offer suggestions.

For the child whose family lives in a remote place, communication carried on through correspondence with a specialized agency and vice versa -- with the service worker serving as intermediary -- can be very successful.

IN SUMMARY

The service worker seeks to assure that the parents or caretakers of eligible SSI and AFDC children, especially during the latter's formative years, receive the best individual guidance in child care and development that is available. Because of the unique nature of the

rehabilitation and educational requirements of these children, the most significant and lasting social service may be to see to it that their parents have access to the appropriate resources for this guidance. The outcome of all efforts in behalf of children who are blind should be to encourage maximum participation in the usual experiences of childhood such as regular schooling, recreational outlets, and a share in family and community life.

CHAPTER V

YOUNG AND MIDDLE ADULT YEARS

VOCATIONAL REHABILITATION REFERRALS

The young adult and the middle aged person who are blind and who qualify for SSI will be considered for vocational rehabilitation provided by their State program. Referral to the rehabilitation agency of those with employment potential is carried out by the State unit where medical proof of blindness and disability is established for SSI entitlement. This procedure applies to recipients under 65 years of age. However a person with a substantial handicap to employment, including blindness, is also entitled to State rehabilitation services through other provisions as a "severely handicapped individual." A person who is not exempt from such an SSI referral because of severe disability must accept the services offered by the State rehabilitation agency as a condition for receipt of this payment. The only exception permitted for refusal is for "good cause." Under the current legislation the blindness factor and the need for and use of rehabilitation services will be reestablished at least quarterly (Title XVI, Section 1615).

This vocational referral, whether or not sought by the SSI recipient, can be of psychological benefit since it identifies him as an individual with the capacity for personal and economic independence. It may oblige him to take on new roles. It may also improve his self-image and enhance his status with others. Furthermore with the assignment of the rehabilitation counselor, he will have on a one-to-one basis the continuing direction necessary to participate in a training sequence appropriate to his interests and ability.

COLLABORATION BETWEEN SERVICE WORKER AND REHABILITATION COUNSELOR

The service worker's function in conjunction with rehabilitation cases would be similar to that intended under Public Assistance/Vocational Rehabilitation collaboration.1/ Essentially this collaboration is

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1/ PA/VR Policies and Practices for Vocational Rehabilitation of Disabled Public Assistance Clients: Resources for Training. New York: Research Utilization Laboratory (240 East 24th Street, New York 10010) 1973 (March). 128 pp.

concerned with supporting the training or retraining plan to assure a successful outcome. Often obstacles to success may originate with family members rather than with the trainee.

The family is an important part of the blind person's environment, and sometimes a recipient's whole problem with a training or retraining sequence is due to the thwarting attitudes of his relatives. These attitudes may not be enunciated in so many words but are significantly revealed in the way family members act out their feelings. For example an emotional need to overprotect the blind person can hinder his right to self-reliance, mobilization of initiative, and utilization of services.

Though the reality of blindness makes a certain amount of dependence upon sighted people unavoidable — e.g., reading menus in a restaurant, identifying buses, learning the physical surroundings of a new job — a realistic boundary should be drawn between what is essential and what is pampering. Household members may be so immature or so fearful that they are unable to sufficiently relinquish their own dependence on the blind person to permit him to benefit from his rehabilitation opportunity. In either of these situations the joint plan with the counselor would customarily be for the social worker to provide such relatives with alternate supports and sources of satisfaction so they can "free" the handicapped member.

MARITAL STRESSES

Marriage counseling may be of paramount importance if an individual unexpectedly becomes blind after marriage. Then a shift in husband-wife roles will frequently take place with respect to finances and lifestyle. A more serious consequence may be the disruption of earlier mutual patterns of emotional reliance, respect, and affection. Because one partner's needs and dependence on the other are increased, the previous reciprocal balance that existed between the couple can be endangered. A marriage that was fragile before the event of visual loss is placed in greater jeopardy. When there are children or others -- related or not — in the household, the number of relationships and the variety of interactions are expanded. Thus the number of readjustments triggered by the occurrence of blindness are correspondingly increased.

If the service worker does not receive from within the agency the consultative guidance she may require in order to carry out counseling in this difficult area, then families in need of such help should be offered the opportunity to use an outside source. Private family agencies and mental hygiene clinics are likely settings.

Associated with the emotional accompaniments of adventitious blindness are, of course, the physical strains present in the traumatic transition

from normal or near normal sight to the status of legal blindness. (An approximation of this experience becomes vivid when a sighted person wears a blindfold or keeps his eyes closed for even 10 minutes and tries eating a meal or walking around.) Following sudden blindness, previously taken-for-granted activities such as dressing, handling money, and using a telephone become major undertakings. Venturing outside presents the risk of being victimized or hurt. The person's accustomed ways of learning, making choices, moving about, and relating to others have been interrupted, and his life must be reprogrammed to accommodate a new situation.

IMPORTANCE OF INSTRUCTION IN ORIENTATION AND EVERYDAY ACTIVITIES

In addition to mastering the common functions referred to in the section on Special Teaching Services (Chapter II) the blind person may want to learn how to use special aids and appliances developed for the visually handicapped and ways to minimize accident hazards in the home.

Teaching of braille and handcrafts are other areas for instruction, if they are suited to the person's wishes and capability.

Individuals who are blind are sensitive about table manners and may want to avoid sharing meals with others, particularly in public. A significant achievement for them, therefore, is learning how to properly locate, identify, and cut food without fingering it or relying upon a sighted person.

Because teenagers and young adults may be self-conscious with their sighted peers, they often avoid situations in which they might make what they consider social blunders. Without direct help to aid them in socializing with the sighted, their feelings of insecurity and their seclusive tendencies may be reinforced.2/

The consistent attention and encouragement of relatives of a blind person give emphasis to the teaching process he is undergoing. At the same time, the relatives need information and guidelines about what he is learning. For example, they should know that different kinds of food should be placed in the same location on the plate (like the quarter segments of a clock) and should not be changed.

The congenitally blind and brain damaged need more help in understanding that there are "proper" table manners and how to use them.

2/ Mary Morrison: "The Other 128 Hours a Week: Teaching Personal Management to Young Blind Adults." The New Outlook for the Blind 68:454-59, 69 (December 1974).

NEED FOR MOBILITY TRAINING

None of us has an innate sense of mobility; competence in travel is a learned skill. Family members and friends may be willing but are rarely equipped for teaching mobility skills to the blind or visually handicapped person, especially since such teaching should be anything but haphazard. Since mobility is one of the major cornerstones for the reconstituted life of a blind person, his chances for personal independence are diminished until he can move safely around in his indoor and outdoor environments with a feeling of self-confidence.

As mentioned in Chapter II, mobility training makes full use of sensory aids and devices and, of course, of any residual sight the individual has. The chief means of accomplishing good travel performance are use of a sighted guide, a dog guide, and/or a properly prescribed cane. To be of maximum benefit, the cane must be carefully selected "to fit" and the user taught how to handle his own type of cane.

Traveling by oneself requires good hearing. Sighted guides need more than good-will; they too must be instructed in guidance techniques which are not self-taught. As for guide dogs, only a small percentage of blind adults use them; those with a hearing loss cannot because the defect interferes with their own learning and with the awareness of cues from the environment (such as traffic sounds). There are now over a dozen recognized training centers for these dogs which must be carefully selected, trained, and matched with their blind masters. At least a month must be spent in the center learning how to work with an animal. Good health is a prerequisite for such a partnership because the dogs are taught to walk at a faster pace than some people can manage. The expense of dog food and possible veterinary fees should not be overlooked. Replacement of one guide dog by another, for whatever reason, means a return visit to the center for a repeat training sequence with the new one.

A clear and practical presentation on the subject of travel performance is the publication entitled How Does A Blind Person Get Around? available without charge from the American Foundation for the Blind. This material would be valuable for friends and relatives of blind people as well as to the service worker herself.

TRAINING FOR HOME AND FAMILY RESPONSIBILITIES

For the blind mother and homemaker, learning to make satisfactory adaptations in order to manage her household is a realistic goal. Rehabilitation teachers, some home economists, and occupational therapists are the experts here who instruct the homemaker in such areas as arrangement of kitchen supplies with braille labels so she can cook and bake; the safe use of a stove and other utensils; the proper way to locate

and coordinate clothing and jewelry, put on makeup, etc. How to sew, play games, and enjoy craft work are also part of this training (or retraining as the case may be).

Teaching personal care and homemaking to those with congenital blindness often follows a slower pace, much like their other kinds of instruction. By contrast, adventitiously blind persons have usually been sighted long enough to form concepts of motion and space and to be familiar with everyday objects and their purpose within an environment designed for people with adequate vision. For example they know what is meant by the center of a frying pan and how to cut a sandwich in two. Such learning is more complicated for people who never had the useful sight that serves as transition for relearning skills and fitting them to changed circumstances.

DIFFICULTIES OF BLIND PARENTS

Blind parents with one or more sighted children have a more complex task than do sighted parents in the raising of children, especially when the children are old enough to realize their parents are not like other parents.

In the physical care of children, there are ways to keep track of babies and small children; for example, by tying a bell on their clothing. "Beep balls" also provide cues. Public health nurses will be helpful instructors here too.

If one parent has vision, things are easier. Even so the child of a blind parent is asked to do more than other children; often he acts as the eyes of his parent and usually has to assume greater responsibility for himself. He is, however, able to "get away with" more. A blind parent may have a problem with discipline since it is hard to know if, when, and how much wrongdoing was the child's fault.

A home helper may be the agency's best solution to complement the rehabilitation teaching that is badly needed in helping blind parents deal with the problem of childrearing. Hopefully this rehabilitation guidance can be obtained.

Day care at some point could both benefit the child and allow the parent some rest from routine responsibilities.

RECREATIONAL NEEDS AND RESOURCES

Recreational outlets are as important to the well-being of blind people as of the sighted. In fact they may be more meaningful by counteracting the social withdrawal that too often accompanies such an impairment.

Besides offering variety and stimulation, activities requiring physical exercise improve body fitness. Lack of or limited mobility creates flabbiness and encourages inertia.

Different methods of teaching recreational skills to people who are blind may have to be used and over a longer period of time, but they can be just as successful as the more traditional methods followed with the sighted. Sometimes special equipment is needed or a sighted companion required to warn about hazards such as those in swimming areas. With some home crafts, no special equipment is necessary; since instructions must be verbal, they can be put on a tape recorder for the person to follow at his own learning pace. Touch as a guide in teaching must be used frequently because visual examples are not meaningful.

Whether the client's age, interests, and health status favor individual and sedentary pursuits or group and outside opportunities, there will be a variety of recreational outlets from which to select. The service worker should encourage participation in the activity of choice, with the family's concurrence. If transportation to reach the recreation location presents a barrier, the worker will need to facilitate travel arrangements either through her agency or a volunteer source.

The blind person may prefer activities where only other blind individuals participate because he feels safer, better able to keep up, or simply because he is more comfortable with other blind people. Among the examples of groups for blind participants only are the American Blind Bowlers Association and specialized camps for the visually handicapped. Emphasis is currently being placed on having blind of all ages share leisure time activities with the seeing and on preparing the latter for the experience. Many senior citizens clubs include the older blind person in their membership with mutual benefit and satisfaction. Blind people are increasingly a source of volunteer manpower.

Knowledge about outside recreation may not reach the blind because they simply "don't get around." In fact the worker herself may not have needed to know of such resources. A council of social agencies might have a listing; the Y's, a local Red Cross chapter, a settlement house, the Scouts, departments of recreation, or perhaps a club may already have or be willing to develop an opening for such clients.

A positive experience with a chosen leisure time activity provides many rewards and, by extending the blind person's horizon, can help him move on to even wider participation in a larger world. For example, for those who expect to enter the labor force, recreational outlets shared with the nonblind are part of and contribute to the reality and mastery of living in a sighted world. Especially for the recently blinded, outside interests serve to counterbalance the despondency and boredom that are likely to set in when active medical treatment is finished and

when, after their initial concern, the attention of friends begins to wane. Often all that is needed to effect this "positive experience" is a knowing and helpful person to bring client and resource together.

SPECIAL INTERNAL REVENUE SERVICE PROVISIONS

A service worker may have occasion to bring to the attention of blind clients -- especially those in this adult group -- the following points.

Legally blind persons are the only handicapped group allowed to claim an additional $750 exemption on their Federal income tax. When both husband and wife are legally blind this figure is, of course, doubled. No similar exemption is made for other dependents, regardless of their visual or physical status. Generally benefits from Social Security sources are not taxable, so it is unlikely an SSI recipient would have to pay a Federal income tax on this resource. The cost and care of seeing eye dogs is allowed as a deductible item.

TRAVEL CONCESSIONS

Under the Interstate Commerce Act of 1927, railroads and bus lines may permit a blind person and a sighted companion to travel together for a single fare. A free pamphlet, Travel Concessions for Blind Persons, available from the American Foundation for the Blind gives current rules and regulations. Identification cards and coupon books are necessary in order to use this concession; the Foundation officially administers the one-fare travel privilege.

The idea of asking for reduced travel rates is repugnant to some blind people who feel it is discriminatory because it sets them apart as a special group.

IN SUMMARY

Among the clients of the State agency, the young adult and middle aged population is the one with a percentage who qualify for State vocational training programs. When case planning is shared with the rehabilitation counselor, worker services may be directed to the rehabilitant's family if their difficulties interfere with client progress. Marital problems accentuated by limitation of effective sight and the difficulties of child rearing are most evident in this period between childhood and late life. Opportunities for professional instruction in mobility, personal care, and home management as well as referral for recreation activities are important linkages the service worker can establish with providers in the client's behalf.

CHAPTER VI

ELDERLY AND BLIND PERSONS

As the Metropolitan Life Insurance Company study (referred to in Chapter III) shows, the rate of blindness for persons 65-74 is more than double the rate for those aged 45-65; it more than doubles again between 75-84 years; and, after age 85, is 13 times more frequent than the rate for the "young-old" (i.e., 65-74).

Under the original provisions of SSI, age rather than an impairment was an eligibility determinant for those 65 and older, so the possibility of establishing legal blindness as a criterion for eligibility for that age group was not taken into account. Subsequent revisions in the law allow (at the option of the State) elderly legally blind persons who are otherwise eligible to be accepted as blind SSI recipients if it would mean a monetary advantage to them.1/ Regardless of such classifications, there is likely to be more need for social supports by eligible elderly people with severe sight problems than by persons younger than 65 who meet the definition of legal blindness.

Securing a visual diagnosis when such information is lacking, verifying the need for medical eye treatment, and assuring continuation of recommended care to completion are proper concerns of the service worker. Medicare and Medicaid provisions are the major resources for these responsibilities.

Because poor sight may slowly progress to the level of blindness and at the same time be painless, an older person with other health problems that do hurt and hinder tends to complain more about them. But the presence of these other impairments emphasizes how necessary it is to protect and restore any useful sight the individual may have. The too ready acceptance of debilitation as a normal part of aging also discourages utilization of comprehensive medical care. Consequently many older people allow themselves to become worse through neglect that is often due to ignorance.

An ophthalmologist can quickly diagnose and prescribe a treatment regimen for visual problems. Much can be done in the way of restoring

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1/ Title XVI -- Part 20 of the Code of Federal Regulations, Section 416.2015(e) -- amended, effective February 21, 1975.

sight, of preventing further visual loss and, through use of prescribed visual aids, of enhancing the usefulness of even a minimum amount of residual vision. Furthermore eye surgery is not as incapacitating and distressing as are many other kinds of operations. Cataract surgery -- a very common procedure for older people — is 90 to 95 percent successful, and this figure includes those past age 90. The hospital stay is relatively short and, even while adjusting to cataract glasses, the person may begin to see better. Since a sizeable number of blind people live alone, this recovery timetable is an encouraging factor they should know about.

NEED FOR DIAGNOSIS AND MEDICAL EYE CARE

An unfortunate amount of sight is lost because senile cataracts are not diagnosed and treated. (There are some instances when, because of other physical problems, an operation is not recommended.) Surgery is the only method; claims made in the past that cataracts can be dissolved are quackery.

The Industrial Home for the Blind (Brooklyn, New York) screened 5,376 persons living in 36 nursing homes and 20 homes for the aging. The median age of the residents was 82. Among other conclusions it was found that many of the 19 percent who failed the screening procedures and were presumed blind had operable cataracts. In general the visual needs of the residents had been overlooked. The study also showed that these institutions had "grossly underestimated" the incidence of visual loss.2/ In 1969 the Division of Services to the Visually Handicapped, Department of Social Services, South Dakota, undertook a similar survey in which 2,578 nursing home patients were screened. Of this total, 13 percent were legally blind and 32 percent needed medical eye treatment or the services of an agency serving the blind.3/

These studies indicate the widespread, unmet visual requirements of the elderly. Though it has not been documented in a similar way, our increased lifespan has resulted in a mounting number of homebound, and correspondingly more of this older group are without useful vision. The service worker with a majority of elderly in her caseload is in an advantageous position to recognize their visual problems and to take constructive action.

2/ Herbert Rusalem: "A Study of the Incidence of Blindness in Homes for the Aged and Nursing Homes." The New Outlook for the Blind 63: 168-174 (June 1969).
3/ Howard H. Hanson: "Vision Screening of the Aged." The New Outlook for the Blind 65:213-215 (September 1971).

COMBINED SERVICE NEEDS OF THE ELDERLY AND BLIND

It may be a moot question whether blindness in an old person is a problem of aging or of sight loss since they have so many common factors. Certainly the range of services that benefit all elderly is of equal or even greater value to the elderly blind. There are differences in this stage of the life cycle as in earlier periods between those who were born blind, became blind as youths or as adults of working age, or lost their sight gradually or suddenly in old age. These are different kinds of events, and effective social service planning will be cognizant of each individual's unique response to his losses.

When someone who is already deaf becomes sightless, the combination is often overwhelming and calls for special help and understanding. For any visually handicapped age group, preservation of hearing is a "must" goal. The blind have to rely heavily upon this sense for auditory cues and communication to counterbalance the visual deficit, since the latter has greatly reduced their capacity for gathering information.

Blindness late in life compounds other deprivations that are occurring such as loss of work and income, illness or death of the marital partner, a diminished role in the lives of grown children and in community affairs.

The necessity of assuming everyday tasks without useful vision -- often combined with other sensory deficits -- creates severe stress at the time older persons have less stamina and greater difficulty in learning substitute ways. The principal assistance they want, need, and can manage may consist of providing instruction on how to move safely around their living quarters and to care for their personal needs.

If the elderly person never did much reading, then listening to the radio is likely to be more pleasurable than using a talking book machine. In contrast to those who are less ambitious, some blind elderly are able to invest a good deal of effort in learning techniques for outside travel, braille reading and writing, and participation with sighted companions in all sorts of community events. Whatever the client's life style and aspirations, the goal of social services will be "to help him on his way," within the limits of safety and the preservation of his health.

Because the elderly blind who live alone have a special vulnerability to hazards of all kinds, they need particular attention. Having a telephone (and knowing how to use it) is one practical kind of help. Safe cooking, lighting, and heating equipment are other kinds. When the sense of smell is deficient, use of gas stoves is contraindicated because leaking fumes cannot be detected. Homemaker, chore service, transportation, home delivered meals, volunteer visitors, and other services regularly provided to all agency clients, of course, benefit blind recipients whether or not they live alone.

ATTENTION TO THE INSTITUTIONALIZED

Many who are old and blind live in hazardous circumstances. They require the protection of foster care, a boarding situation, or a medical setting. With worker encouragement the transition to a protective environment can often be made without great distress. Interpretation of the special needs of this group to the administrator or caretaker in the new setting may also be up to the worker.

More attention is now being given to instruction to staffs of institutions on the care of older visually impaired persons. In the past many nursing homes refused to admit blind patients because their care "would be too burdensome." The same reason was given by some other settings offering long-term care; however, these places did not usually discharge residents who became blind after admission. Though certain procedures must be changed to accommodate the requirements of the blind, they are not sweeping ones. The extent of need for training and rehabilitation in areas of mobility and self-care will depend upon past competence of the individual.

The Minneapolis Society for the Blind has developed (through the use of a Title III project under the Older Americans Act) a concise, illustrated guidebook for facilities and agencies serving older blind people.4/ Much of the content will be of value to agency workers and to friends and relatives who share everyday experiences of the blind of any age.

CONTRIBUTION OF VOLUNTEERS

Volunteers can make a significant contribution to the happiness and comfort of the visually handicapped. Directly or indirectly their interest also benefits other members of the family or the caretaker person. Many of them will welcome a respite -- even though only for a few hours -- to be free from responsibility for the safety of a blind dependent. Some agencies give special training to their volunteers who want to work with the visually handicapped. Not all volunteers, however, feel comfortable in such an association.

A volunteer can be useful in many ways such as serving as a sighted escort to obtain medical care, shopping, performing banking and other reasonable errands, reading and answering mail, attending religious and recreational activities, or calling on friends and relatives. Sometimes the person prefers to be read to or just to have the volunteer visit.

4/ Caring for the Visually Impaired Older Person: A Practical Guide for Long Term Care Facilities and Related Agencies. Minneapolis, Minn.: The Minneapolis Society for the Blind (1936 Lyndale Avenue South, 55043) 1970. 46 pp.

If the blind person does not speak English, he will need an interpreter as well as a sighted helper, services preferably provided by the same individual. The nature of a volunteer's activities will largely depend upon the wishes, age, and physical and mental health of the visually handicapped person and his setting.

Transportation is a pressing need for many able-bodied elderly. For the elderly blind, it poses an even greater dilemma. Those who are frail or have additional impairments may only feel safe in moving about inside the home. To venture further requires a sighted companion and some means of transportation. However participation in outside events should be encouraged since, by doing so, the person's horizons are enlarged. Also exposure to stimulating experiences makes him less prone to the harmful introspection and regression encouraged by constant confinement within four walls. Social isolation is self-reinforcing. For the elderly who are in an institution, house- or bed-bound at home, the visits by a volunteer worker can provide a window to the outside world.

Sustained volunteer attention bolsters the blind person's self-respect by making it possible for him to have more choices and to carry out more decisions. Enabling him to negotiate transactions that could not be accomplished independently fosters a sense of well-being and self-direction. Relationship with a volunteer is also reassuring because her presence is tangible evidence that the recipient who is blind has a reliable friend and advocate in addition to the social worker.

IN SUMMARY

Social services for agency clients 65 years of age and over focus on the problems of aging and on the consequences of severe visual impairment. The self-respect and independence of this large group should be encouraged. The purpose will be furthered by aiding in the restoration of sight, in the preservation of their residual vision and, so far as possible, correcting hearing difficulties. Supportive services in conjunction with cataract surgery are often essential. Use of talking books brings pleasure to many who want material not offered on radio and television. Instruction from rehabilitation teachers — particularly for those living alone or with others who are frail — will allow many to continue their customary activities safely and with even greater success. The variety and stimulation brought by volunteers to blind people, whether in an institution or community setting, complement the worker's functions. Because of the double handicap of age and eye pathology, many clients, for understandable reasons, tend to be passive and stay out of the mainstream of everyday life. Since their presence is easily overlooked, the social service worker has to be more active in locating clients in need of agency attention.

CHAPTER VII

CONCLUSION

The earlier chapters in this document presented content about the social implications of severe visual impairment. Particular emphasis was given to the role of the department of public social services worker for the provision of social services to legally blind agency clients and those 65 years of age or older with serious loss of sight.

The life span of this population, from infancy through old age, exposes the worker to a broad variety of problems and service needs. Blind persons who have never received public assistance will be entering the SSI program in increasing numbers. It is likely that many have not been known to any service organization associated with the blindness system. This is another reason for the service arm of the public agency to reach the more recently accepted group and to actively offer the help that neither they nor their families have discovered.

Blindness, in proper perspective, is a physical disability which causes certain problems. Disrupted life patterns must be faced when sighted people lose their vision. Blindness is not the equivalent of any other handicap. This circumstance reflects a double impact: the reality of severe visual loss with related social dependence, plus an emotional overlay composed of many elements.

For the sighted, personal concerns are likely to include the common dread of becoming blind, the feeling of guilt for not being blind, uncertainty about ways to assume a helping role, and general mystification over how blind individuals manage even ordinary tasks and often display such cheerful attitudes. By gaining deeper insight into the meaning of blindness to the client and his relatives, as well as recognizing her own inner feelings concerning loss of sight, the social worker will be better prepared to offer both suitable and acceptable services.

Though blindness is a primary factor determining the organization of the lives of the visually handicapped and influencing their relationships with others, blind individuals are more like than different from the sighted. With this understanding, the uniqueness of each client becomes more visible to the worker. Such individualization will counteract a common tendency that allows the visual impairment to dominate recognition that each of "the blind" also has and must maintain his separate identity.

Use of these concepts will assist the agency worker in establishing a meaningful dialogue with clients. It is her responsibility to acquaint and encourage client use of her department's resources and those of allied programs. A mutual objective of their association is to enable the visually handicapped client to reach and sustain his upper limits for personal and economic independence.

A single need readily met by a single service is more often the exception than the rule in the provision of social services. Thus the social worker should have a combination of factual knowledge about all the resources of her own program and the services available from related organizations, in addition to skill in communicating with others and facilitating client progression toward attainable goals. A number of the latter — such as instruction in mobility, personal adjustment, and educational and vocational training — are in the province of related programs. An important social service responsibility is to make sure that SSI recipients and other eligible persons are informed about and assisted in using such opportunities. The firm linkage with outside providers of specialized services is a collaborative endeavor that sometimes continues for a lengthy period. The exchange is necessary to keep patterns of service in balance and responsive to changes in plans that frequently accompany both intra- and interagency work.

The service worker becomes the image of the social service agency to client households since she is the only personal representative of the program that families are likely to meet. Whether the blind individuals are young or in middle or old age, the social worker is in a propitious position to learn "how life goes for them," about their accommodation to visual loss, about their expectations for the future. These indicators should focus agency attention on clients' assets that can be preserved and developed.

The helping process is relevant even though the gains may not be substantial. Most blind people, like the rest of us, respond favorably to a sincere approach. When free to make informed choices, there should be movement toward achievements that are consistent with their interests and community opportunities.

Many service workers have not had either previous work experience or training that provided information about the special aspects of visual loss. Few have asked to be affiliated with the blindness system. But by serving this group of seriously impaired people, the worker can derive new and deeper insights that will prove to be personal gains. State training division effort directed to this subject area would build up the prerequisite knowledge and skills.

The public agency setting offers its service staff a rich though often soul-searching opportunity to know and participate in improving the daily existence of a large number of blind citizens. This, in brief,

is the mission embodied in all the related Federal, State, and local social service legislation and directives. The mission only becomes reality when client and agency social worker together translate intent into actual services.

SUGGESTED REFERENCES AND FILMS *

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Krents, Harold: To Race the Wind: An Autobiography. New York: G.P. Putnam Sons, 1972. 282 pp.

(Part of Mr. Krent's life was the basis for "Butterflies Are Free," the play, and later the film by the same name.)

Lipton, Edgar L., M.D.: "Psychological Preparation for Eye Surgery." The Sight-Saving Review 43:203-212 (Winter 1973-74).

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* Because charges for pamphlets, books, reprints, and films (loan, rent, or purchase) fluctuate, current prices should be requested directly from the producer or publisher. However many pamphlets, often up to 50 copies, may be available without charge to interested agencies.

Newell, Frank W., M.D., and Ernest, Terry J., M.D.: Ophthalmology: Principles and Concepts (3rd edition). St. Louis: C.V. Mosby, 1974. 529 pp.

PLAYS AND FILMS

"Butterflies Are Free" — Leonard Gershe. New York: Random House, 1970.

Play depicts the experiences of a young blind man who establishes his independence by leaving home to move into an apartment in Greenwich Village. (Note preceding reference to Harold Krent's autobiography.)

"Butterflies Are Free" was made into a film of the same title; screenplay by Leonard Gershe; directed by Milton Katselas, 1972.

"Cataract" — National Society for the Prevention of Blindness. 13-1/2 minutes, 16 mm., color.

An informational film for general audiences featuring Sylvia Sidney with Leonard Flom, M.D. The film is about the personal recollections of this actress as she faced loss of sight from cataracts, sought help, and regained her vision. (Prints on loan, free of charge, or by purchase.)

"The Miracle Worker" — William Gibson. New York: Knopf, 1957.

A play about the early education of Helen Keller, the deaf-mute and blind girl, and her teacher, Annie Sullivan.

Also a film, "Helen Keller and Her Story," 1954, 55 minutes, 16 mm., black and white. (This film updates the 1945 film produced by Nancy Hamilton for the American Foundation for the Blind.) Narrated by the late Katherine Cornell, the film won the 1955 Academy Award for the best feature length documentary. It is a factual biography, with Miss Keller appearing in scenes from her daily life.

INFORMATIONAL MATERIALS

Available from American Foundation for the Blind

PUBLICATIONS

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Finestone, Samuel; Lowery, Fern; Whiteman, Martin; and Lukoff, Irving: Social Casework and Blindness, 1960. 115 pp.

Lairy, G.C., M.D. and Harrison-Covello A., M.D.: The Blind Child and His Parents: Congenital Vision Defect and the Repercussion of Family Attitudes on the Early Development of the Child. Reprint from Research Bulletin No. 25, January 1973. 24 pp.

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Miller, Irving: Resistance to Cataract Surgery. Research Series No. 12, 1964. 110 pp.

FILMS

"Not Without Sight" — 1973. 19-1/2 minutes, 16mm., color.

Defines five major severe visual impairments (glaucoma, cataracts, macular degeneration, retinitis pigmentosa, and diabetic retinopathy), examines their causes, and illustrates how people with such sight loss "see the world around them." The film covers the three main types of visual impairments: (1) where overall vision is obscured, (2) where edges of vision or parts of vision are obscured, and (3) where the center of vision is obscured.

OTHER

Aids and Appliances Catalog

In print and braille editions, issued annually, and free on request, this catalog describes dozens of devices to

assist the blind to carry on activities of everyday living. These items can be ordered at cost.

Catalog of Publications

Issued annually and free on request, this catalog lists over 60 public education materials including reprints of articles from The New Outlook for the Blind on subjects such as guide dogs, facts about blindness, the needs of preschool blind children, what to do when you meet a blind person, recreation for blind adults, and travel concessions. Two Public Affairs Committee pamphlets — Living With Blindness and What Can We Do About Limited Vision? — are also distributed by AFB. Many AFB publications are available free of charge in quantities up to 50.

Directory of Agencies Serving the Visually Handicapped in the United States

Published every 2 years, this directory contains the names, addresses, and programs of almost all private and governmental services for visually handicapped persons.

The New Outlook for the Blind

This is a leading professional journal for persons concerned with blindness and visual handicaps. It is published 10 times a year in print, braille, and in recorded editions.

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Available from National Society for the Prevention of Blindness

Pamphlets entitled:

The Aging Eye: Facts on Eye Care for Older Persons

Cataract: What It Is and How It Is Treated

Sunglasses: Know What You're Getting and What They're Really For

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Address correspondence as follows:

- American Foundation for the Blind
  15 West 16th Street
  New York, New York 10011

  for Film Information — Attn.: Film Library
  Public Education Division

  for Publications — Attn.: Publications Division

- National Institutes of Health
  National Eye Institute
  9000 Rockville Pike
  Bethesda, Maryland 20014

- National Society for the Prevention of Blindness
  79 Madison Avenue
  New York, New York 10016

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